Workgroup I: Cardiovascular Disease

The first session of the Arkansas Healthcare Payment Improvement Initiative Cardiovascular Disease Workgroup convened on October 26, 2011 to discuss opportunities to ensure quality and efficiency of patient care in Arkansas. The workgroup meeting was the first in a series of discussions, which will inform the design and implementation of a new payment model.

Approximately 70 Arkansas healthcare professionals and patients were in attendance at the first workgroup, representing perspectives of patients, providers (cardiologists, cardiac surgeons, internists, family medicine physicians, pharmacists, nurses), hospital leaders, advocacy groups, public health experts, nonprofit administrators, government officials, and others.

The first workgroup focused on congestive heart failure (CHF). Key components of the discussion are summarized below.

KEY COMPONENTS OF WORKGROUP 1 DISCUSSION

- There was broad agreement around the importance of high-quality care, outcomes, and patient experience. In particular, workgroup participants highlighted the opportunities in Arkansas to:
  - *Invest in early education and prevention:* Participants suggested that physicians should discuss family history with well patients to fully understand their risk of CHF. Early detection and treatment of hypertension was also cited as a key opportunity to prevent CHF, with only 39% of people with hypertension controlled.
  - *Promote more consistent use of evidence-based medicine*: The group acknowledged that there is variation in practice by hospital in key measures (e.g., use of ACE inhibitor or ARB in indicated patients, delivery of discharge instructions). Participants noted that even when the correct medications are used, they are often not titrated to get the full therapeutic benefit, and inpatient providers hesitate to change medication regimens in deference to the outpatient provider.
  - *Reduce hospitalizations / acute exacerbations*: CHF patients are some of the most frequently hospitalized, and interventions have been effective in keeping patients well in the outpatient setting. Some interventions discussed included better early patient education as soon as patient is diagnosed, using remote monitoring to preempt exacerbations if patient condition is worsening, and improving coordination of care between cardiologists and primary care providers.

- *Improve efficiency of inpatient stay:* The group agreed that there was significant variation in length of stay and cost per case at different providers in the state (e.g., for a case mix index at 1.0, length of stay varies from 3.1 to 5.1 days and cost per case ranges from $4,000 to $5,500). The group also agreed that risk-adjustment was critical for evaluating inpatient efficiency and that reducing length of stay too far might adversely affect readmission rates.
- *Ensure appropriate post-discharge medication use:* Participants agreed that medication reconciliation is a key issue in the transition of a patient from the inpatient back to the home setting. Patient confusion about medication changes and failure to fill new prescriptions in a timely way upon discharge were cited as quality gaps.
- *Reduce readmission rates:* The group emphasized the importance of developing an effective approach to patient education. Current discharge instructions were viewed as insufficient. The group agreed that patient education should begin before the condition necessitates hospitalization and continue after discharge, while noting that the acute inpatient event represents a particularly teachable moment. Increased coordination of care among all providers as well as early follow up after discharge and remote monitoring were mentioned as other opportunities to reduce readmission rates; participants also highlighted a successful Arkansas transition nurse program.
- *Reward investment in the doctor-patient relationship and patient education:* The group discussed that while neither of these are reimbursed right now, they are crucial to patient outcomes in CHF; group agreed that a new payment system should reward providers who do these things well.

- Workgroup participants agreed that the current fee-for-service payment model fails to align incentives and does not reward providers who excel at prevention, patient education, and efficient inpatient management. The group viewed a new payment model as an opportunity to promote greater use of evidence-based medicine, coordination of care, and empowerment of patients for improved self management.
- The workgroup discussed the need for payment design and implementation to take into account several important elements, including:
  - *Case load severity* – Recognizing that providers' case load severity differs, and so not constructing a disincentive to serve patients with the most serious risks (e.g., those with significant comorbidities or at advanced stages of heart failure).
  - *Time window* – Considering the extent to which providers can be held accountable for outcomes over the course of a brief time frame after admission (e.g., 30 days) and over a longer time frame (e.g., 12 months).
  - *Coordination across providers* – Recognizing that several different providers (e.g. hospital, primary care physician, cardiologist, home health clinic, etc.) are involved in care and that resources in a payment bundle will need to reflect this.